

**SAMPLE -2-1-2010**

**SAMPLE Physical Therapy Evaluation/Re-evaluation**

**District**\_\_\_\_\_

**School Year**\_\_\_\_\_

<b>Student's Name:</b>		<b>DOB:</b>	
<b>School:</b>			
<b>Therapist:</b>			
<b>Diagnosis:</b>			
<b>Physician:</b>			
<b>Medicaid Number:</b>			
<b>ROM Limitations:</b>			
Muscle Tone:		Kneeling:	
General Observation:		Standing balance:	
Gross Motor Skills:		Stand to floor transition	
Supine to sit:		Cruising:	
Sitting Balance unsupported:		Standing:	
Sitting balance in desk or chair:		Gait:	
Sit to stand from floor:		Steps:	
Sit to stand from chair:		Wheelchair mobility:	
Crawls:			

<b>Equipment and/or Assistive Devices</b>			
School environmental negotiation		School bus	
Mobility form in classroom		Toileting	
Transition within school		Seating in classroom	
Transition time required			
<b>Assessment:</b>			
<b>GOALS:</b>			
<b>PLAN:</b>			
<b>SUMMARY AND RECOMMENDATIONS:</b>			
<b>Physical Therapist's Signature and title:</b>		<b>Date of signature:</b>	

